Orencia® (abatacept) Referral Form

Preferred Clinic (select one): _____

VIVO infusion®

PATIENT INFORMATION ☐ New Referral ☐ Updated Referral ☐ Referral Renewal

DOB: Patient Name: Patient Phone:

Patient Address: Patient Email:

☐ NKDA Allergies: Weight (kg): Height:

ICD-10 Code (required): ICD-10 Description: Last Infusion Date: Last 4 Digits SSN:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

Physician Preferred Method of Contact: ☐ Email: ☐ Fax: ☐ Phone:

STANDING ORDERS

☑ Infusion to be administered per Vivo protocols.

LABORATORY ORDERS

☑ **Clinic Specimen Collection Authorization: If required labs are not received prior to appointment, infusion clinic staff are authorized to draw required labs under the referring provider's NPI and route results back to the referring office.**

☐ CBC w/ diff every _____

☐ CMP every _____

☐ CRP every _____

☐ OTHER _____

PREMEDICATIONS

☐ acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV

☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV

☐ Other: _____

Dose: _____ Route: _____

ORENCIA ADMINISTRATION

☐ **INITIAL/RELOAD AND MAINTENANCE DOSING:**
Administer at 0, 2, and 4 weeks, and then every 4 weeks
Body Weight of Patient Dose
Less than 60 kg (500 mg)
60 to 100 kg (750 mg)
More than 100 kg (1000 mg)

☐ **MAINTENANCE DOSE ONLY:**
Administer every 4 weeks
Body Weight of Patient Dose
Less than 60 kg (500 mg)
60 to 100 kg (750 mg)
More than 100 kg (1000 mg)

☐ **Other:**
Administer _____ mg
every _____ weeks

REQUIRED DOCUMENTATION

☐ **Patient Demographics**
☐ **Insurance Card/Information**
☐ **Progress Notes Supporting DX**
☐ **Current Medication List and H&P**
☐ **Hep B Surface Antigen** (within 36 months)
☐ **TB Results** (within 1 year)
☐ **Heb B Core**

Provider Name (Print) **Provider Signature** **Date**

Email Referrals To: referrals@vivoinfusion.com OR Fax Below

Have a Question? Call (720) 902-4111

Colorado: 303-418-4679
Connecticut: 203-724-4838
Florida: 904-930-4211
Massachusetts: 781-202-1629
Michigan: 833-957-2188
Minnesota: 763-290-0903
New Jersey: 609-955-3711
New York: 800-540-1852
Ohio: 216-400-0674
Oklahoma: 918-770-4421
Pennsylvania: 215-399-9244
Texas: 469-340-0044
Virginia: 804-500-5941
Wisconsin: 414-600-5383

Referral is valid for one year unless otherwise noted.

Revision Date 11/2026